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Supporting women to breastfeed: still an issue despite evidence of benefit?

Professor Debra Bick & Dr Yan-Shing Chang

Background

The World Health Organisation recommended in 2002 that babies should be exclusively breastfed (that is, that no other fluids or foods should be offered) for a minimum of six months post-birth. Despite this advice and evidence on the benefits for women and their infants, the UK has the lowest breastfeeding rates in Europe. In 2010, only 17% of women were still breastfeeding exclusively at three months and at six months the figure was 1%.[1] Even though measures to improve uptake and continuation of breastfeeding have been rolled out across NHS secondary and primary care settings, significant improvements have not been achieved.

What influences uptake and duration of breastfeeding?

Social and demographic differences are the main influence. Fifty-eight percent of women aged under 20 commenced breastfeeding in 2010 compared with 87% aged 30 and over. Younger women of white British ethnicity with fewer educational qualifications, living in more economically deprived settings are least likely to start or continue breastfeeding.[1-2]

There is also evidence that women who experience birth complications associated with complex medical conditions and interventions such as caesarean section are less likely to start breastfeeding or stop breastfeeding sooner than other women.[3-4] However, even for those women experiencing severe maternal morbidity (major obstetric haemorrhage, severe hypertensive disorder or high dependency/ intensive care unit admission) breastfeeding rates are associated more with socio-demographic factors (age, ethnicity, living arrangement).[5]

What to say about the evidence on benefits of breastfeeding?

- For the infant: lower risk of gastrointestinal infection, otitis media, asthma, allergies, respiratory tract infection, type 1 diabetes and sudden infant death syndrome.
- For the woman: reduced risk of certain cancers, including ovarian and breast cancer, and type 2 diabetes; delayed resumption of menses and more rapid postpartum weight loss.
- Other benefits include: evidence of protection against childhood obesity, which may persist into adulthood; fewer cognitive development and behavioural problems in breastfed children compared with children not breastfed; and improved maternal-infant bonding.

Supporting women to breastfeed: what does the research show?

Midwives and health professionals working in hospital and other birth settings can encourage breastfeeding uptake by: ensuring skin to skin contact as soon as possible following birth; not separating mothers and babies within the first hour post-birth unless medically indicated; avoiding supplemental feeding of breast fed infants; not advertising or promoting artificial milk; and promoting the Baby Friendly Hospital Initiative Ten Steps to Successful Breastfeeding[6-7]

Women experiencing medical complications and caesarian birth need tailored information about potential difficulties

Florence Nightingale Faculty of Nursing & Midwifery
King's College London
James Clerk Maxwell Building
Waterloo Campus
57 Waterloo Road
London SE1 8WA

Tel 020 7848 3048
Email practiceplus@kcl.ac.uk

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with breastfeeding, such as post-operative pain or onset of a wound infection. They need warning that lactation can be delayed following surgery, and positive advice and support to hand express breast-milk and use a breast pump. Tailored emotional support is required for feelings of failure, guilt and self-blame if, for example, women use formula milk or alternatively persevere with breastfeeding but their infants lose excessive weight as a result.[5;8]

For all women common reasons for stopping breastfeeding early (within the two weeks post-birth) include sore nipples, perceived inadequate milk supply, engorgement and mastitis. Such physical problems can all be prevented or resolved with support to position and attach the baby on the breast correctly. However, lack of support in the first few weeks post-birth is frequently reported in surveys of women's experiences of maternity care. Addressing this problem, requires peer support (e.g. by volunteers) and tailored input from health professionals[9] including health visitors.

With their combination of technical skills (e.g. helping women to understand about their babies' weight gain) and their continued active engagement with mothers in the context of the home, neighborhood and community, health visitors can both support women in general and tailor practical and emotional support to women experiencing medical complications and those in different socio-economic groups.[10]

What else needs to happen?

If more women can breastfeed successfully for as long as they want to with the support they need, it could reduce the burden of acute and chronic disease – and this would benefit us all. However, low breastfeeding rates cannot be resolved if viewed only as a health 'problem'. If breastfeeding is to become the 'norm' in the UK as it is in many other countries, then socio-cultural values must change. Health professionals can play a key role in advocating for such a holistic approach across education, social and employment policy and media portrayals of birth and body images.

Key points for practitioners

- Evidence of the health benefits of breastfeeding and importance for health during the life course is clear. Low uptake is a major public health concern with potential inter-generational impacts.
- NICE recommends several interventions to increase breastfeeding uptake including: skin to skin contact following birth, not separating mothers and babies within the first hour unless medically indicated, avoiding supplemental feeding, and not advertising or promoting artificial milk in hospital.
- Common physical problems leading to early cessation of breastfeeding can be prevented or resolved with appropriate support in the first few weeks post-birth.
- Social, environmental and educational interventions to reduce barriers to breastfeeding are needed alongside health initiatives.
- Midwives and health visitors need to implement continuity of care and support for breastfeeding tailored to individual women's needs across secondary and primary care settings.

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